STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING _____ B. WING _____	R-C 10/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-ROLLING HILLS	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This visit was for a Post Survey (PSR) to the Recertification and State Licensure Survey completed on August 22, 2014. This visit included the PSR to the Investigation of Complaint IN00153896 completed on August 22, 2014.

This visit was in conjunction with the Investigation of Complaint IN00156344.

Complaint IN00153896 - Corrected.

Survey dates: October 8 and 9, 2014

Facility number: 000526
Provider number: 155488
AIM number: 100266970

Survey team:
Gloria J. Reisert, MSW/TC
Joshua Emily, RN
Jennifer Sartell, RN
Trudy Lytle, RN
Gwen Pumphrey, RN (10/8/14)

Census bed type:
SNF/NF: 91
Total: 91

Census payor type:
Medicare: 7
Medicaid: 65
Other: 19
Total: 91

Kindred Transitional Care - Rolling Hills was found to be in compliance with 42 CFR Part 483,

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING _____ B. WING _____	R-C 10/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-ROLLING HILLS	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 Subpart B and 410 IAC 16.2-3.1 in regard to the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey and the PSR to the Investigation of Complaint IN00153896. Quality Review completed on October 10, 2014, by Brenda Meredith, R.N.	{F 000}		